ALABAMA MEDICAID AGENCY REFERRAL FORM

Today's Date _____ Referral Date _____

RECIPIENT INFORMATION

Recipient Name	Recipient #:	Recipient DOB:

PRIMARY PHYSICIAN	**SCREENING PROVIDER (IF DIFFERENT)**
Name:	Name:
Address:	Address:
Telephone #: ( )	Telephone #: ( )
Fax #: ( )	Fax #: ( )
Provider #:	Provider #:
Signature:	Signature:

TYPE OF REFERRAL

❑ Patient 1st	❑ Lock-in
❑ EPSDT Screening Date _____	❑ Patient 1st/EPSDT Screening Date _____
❑ Targeted Case Management (TCM)	

LENGTH OF REFERRAL

Referral Valid for _____month (s) or _____visit (s) from referral date

REFERRAL VALID FOR

❑ Evaluation Only	❑ Treatment Only
❑ Evaluation and Treatment	❑ Hospital Care (Outpatient)
❑ Referral to other provider for identified condition	❑ Performance of Interperiodic Screening (if necessary)
❑ Referral to other provider for additional conditions (diagnosed by consultant)	

Reason for Referral:

Co-morbid Diagnosis:

CONSULTANT INFORMATION

Consultant Name: Consultant Telephone #: ( )

Note: Please submit written report of findings including the date of examination/service, diagnosis, and consultant signature to Primary Physician.

Please submit findings to Primary Physician by:

❑ Mail	❑ Fax # ( )
❑ E-mail	❑ In addition, please telephone

Completion Instructions
For
The Alabama Medicaid Agency Referral Form (Form 362)

TODAY'S DATE: Date form completed.
REFERRAL DATE: Date referral requested
RECIPIENT INFORMATION: Patient's name, Medicaid Number, and date of birth.
PRIMARY PHYSICIAN: Primary Physician information. Must be signed by Primary Physician or designee.
SCREENING PROVIDER: Screening provider must complete and sign if referral is the result of an EPSDT screening and the Screening Provider is not the Primary Physician.

TYPE OF REFERRAL:

- *Patient 1st* - Referral for Patient 1st recipient only.
- *Lock-In* - Referral for recipients on lock-in status who are locked in to one doctor and/or one pharmacy.
- *EPSDT* - Referral resulting from an EPSDT screening of a child **not in** the Patient 1st program – indicate screening date.
- *Patient 1st/EPSDT* - Referral is a result of an EPSDT screening of a child that **is in** the Patient 1st program– indicate screening date.
- TCM - Referral for case management services through the Targeted Case Management Program.

LENGTH OF REFERRAL

- Indicate the number of visits/length of time the referral is valid for.
  Note: If this space is left blank the referral is not valid.

REFERRAL VALID FOR:

- *Evaluation Only* - Consultant will evaluate and provide findings to Primary Physician.
- *Treatment Only* - Consultant will treat for diagnosis listed on referral.
- *Evaluation and Treatment* - Consultant can evaluate and treat for diagnosis listed on the referral.
- *Hospital Care (Outpatient)* - Consultant may provide care in an outpatient setting.
- R*efer to Other Provider For Identified Condition* - After evaluation, consultant may, using Primary Physician's provider number, refer recipient to another specialist as indicated for the condition identified on the referral form.
- *Performance of Interperiodic Screening (if necessary)* - Consultant may perform an interperiodic screening if a condition was diagnosed that will require continued care or future follow-up visits.
- *Referral To Other Provider For Additional Conditions (Diagnosed By Consultant)* – Consultant may refer recipient to another specialist for other diagnosed conditions without having to get an additional referral from the Primary Physician.

REASON FOR REFERRAL: Indicate the reason/condition the recipient is being referred.

CO-MORBID DIAGNOSIS: Indicate any condition present at the time of initial exam.

CONSULTANT INFORMATION: Consultant's name and telephone number.

PLEASE SUBMIT FINDINGS TO PRIMARY PHYSICIAN BY: The Primary Physician should indicate how he/she wants to be notified by the consultant of findings and/or treatment rendered.